DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 4 -- 0 9

2. STATE: MO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 07/01/2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440 42 CFR 447.302 42 CFR 460
42 CFR 447.201 42 CFR 447.301

7. FEDERAL BUDGET IMPACT: No additional cost
a. FFY _____ $_____
b. FFY _____ $_____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See attached

9. PAGE NUMBER OF THE SUPERSEDES PLAN SECTION OR ATTACHMENT (If Applicable):
See attached

10. SUBJECT OF AMENDMENT:
To allow individuals assessed by the Department of Health and Senior Services, Division of Senior Services and Regulation at a level of care of 18 points to enroll in the Program of All-Inclusive Care for the Elderly (PACE).

11. GOVERNOR'S REVIEW (Check One)

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT cc
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPE NAME:
Steve Roling

14. TITLE:
Director

15. DATE SUBMITTED:
July 14, 2004

16: RETURN TO:
Department of Social Services
Division of Medical Services
615 Howerton Court
P.O. Box 6500
Jefferson City, MO 65109

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
July 15, 2004

18: DATE APPROVED:
January 4, 2005

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

A. Readiness Review: The State will perform a Readiness Review of the applicant entity that assures the entity has fully developed its policies and procedures, obtained commitments from key staff, developed its solvency plan and has a facility that meets State and Federal requirements at the time of the application, in accordance with Section 460.12(b)(1).

B. Monitoring During Trial Period: During the trial period, the State, in cooperation with HCFA, will conduct comprehensive reviews of a PACE organization to ensure compliance with State and federal requirements.

At the conclusion of the trial period, the State, in cooperation with HCFA, will continue to conduct reviews of a PACE organization, as appropriate, taking into account the quality of care furnished and the organization's compliance with State and federal requirements.

C. Annual Monitoring: The State assures that at least annually it will reevaluate whether a participant meets the level of care required under the State Medicaid plan for coverage of nursing facility services. The State understands that this determination may be waived if there is no reasonable expectation of improvement or significant change in the participant's conditions because of the severity of a chronic condition or the degree of impairment of functional capacity.

D. Monitoring of Corrective Action Plans: The State assures it will monitor the effectiveness of corrective actions required to be taken by the PACE organization.

III. Rates and Payments

A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. __ Rates are set at a percent of fee-for-service costs
2. __ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. __ Adjusted Community Rate (please describe)
4. X Other (please describe) See Proprietary and Confidential letter from Mercer Government Human Services Consulting dated 05/21/2004 - St. Louis Area PACE Upper Payment Limit and Rate Development.

B. X The rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

William H. Mercer, contact Angela WasDyke, (612) 642 8892.

See Proprietary and Confidential letter from Mercer Government Human Services Consulting dated 05/21/2004 - St. Louis Area PACE Upper Payment Limit and Rate Development.

C. X The State will submit all capitated rates to the HCFA Regional Office for prior approval.

IV. Enrollment and Disenrollment: For both State Medicaid Agencies and State Administering Agencies, the State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month. In cases where the State Medicaid Agency is separate from the State Administering Agency, the State Medicaid Agency assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the two agencies.

A. Enrollment Process (Please describe):

The participant must reside in the specific geographic locale (St. Louis and County); be age 55 or older; be assessed at the level of care (LOC) of 18 points or higher by Missouri Division of Aging (DA).

Participants who are state only ME codes (Blind Pension (BP), CWS Foster Care (CWS-FC), General Relief (GR), DYS-General Relief, Catastrophic-QMB, Adoption Subsidy-HDN, Presumptive Eligibility (Non-Subsidized), CWS-HIF, or (IM-GH-HIF) may enroll in the PACE program even if they do not qualify for Medicaid payment of the premium. Enrollment in this voluntary program is as follows after the above criteria has been met

- Missouri Division of Aging keys into the LTACs system the PACE enrollment with the effective date being the first day of the month following signing of the enrollment agreement. This information is then transferred to the Division of Medical Services' management information system;

- The management information system will generate a letter to the participant and the PACE organization advising that the client is now enrolled with the PACE organization with the effective date of enrollment for all services to be provided by the PACE organization;

- Enrollment continues as long as desired by the participant regardless of change in health status, until death, voluntary disenrollment, or involuntary disenrollment as described below.

- The Missouri Division of Aging (DA) will do annual level of care assessments on Medicaid eligible participants as well as private pay participants face-to-face.

- The PACE provider's participant multidisciplinary team evaluates the participant's ability to live safely in the community. The Missouri Division of Aging (DA) involves the participant in their service planning and care planning in collaboration with the PACE provider and the Division of Medical Services (DMS), to determine the participant's capacity to consent. If the DA and the PACE provider disagree about the safety of the participant living in a community setting, discussions would be held with the Missouri Division of Medical Services to review documentation and come to a decision.

- The state administering agency, the Missouri Department of Social Services (DSS), Division of Medical Services (DMS), receives a monthly enrollment status report, as well as financial and quality of services reports. These reports are analyzed monthly to determine that appropriate payments and adjustments are made to the PACE provider.

B. Enrollee Information (Please describe the information to be provided to enrollees):

Once the participant signs the enrollment agreement, the PACE organization gives the enrollee: a copy of the enrollment agreement; a PACE membership card; an emergency sticker to be posted in the enrollee's home in case of an emergency; a sticker for the enrollee's Medicare and Medicaid card which indicates that the enrollee is a PACE participant; the member handbook, which includes an explanation of the internal PACE organization's grievance and appeals process; the additional appeal rights that may be initiated under either Medicare or Medicaid, depending upon the participants payer source. If the participant is dually eligible for both Medicare and Medicaid, then he/she may chose to appeal through either the external Medicare or Medicaid process, but not both.

Replacement Page

PACE Upper Payment Limit and Rate Development

Upper Payment Limit (UPL) Methodology

The State follows the methodology required by the Centers for Medicare and Medicaid (CMS) to calculate the PACE UPLs. The State uses historical Fee-For-Service (FFS) data from the three most recent years of complete claims. Claims are included for eligibles meeting the following criteria:

- Age 55 and older;
- With Medicare (dual eligibles) or without Medicare coverage;
- In a nursing home for more than 32 days; and
- Residing in PACE Approved Service Area.

The FFS data reflects only State Plan approved services which will be included in the PACE capitation payment. In addition, this data is adjusted to further reflect populations and services covered such as:

- Removal of graduate medical education (GME);
- Inclusion of patient's liability;
- Reduction for the State's level of pharmacy rebates; and
- Application of any programmatic changes (i.e. fee schedule and/or benefit changes).

Once these adjustments are applied to the data, each year of data is then credibility adjusted and blended to develop a base fee-for-service equivalent (FFSE). Credibility is applied to smooth outliers and to correct skewed distributions in claims history.

The blended FFSE is trended to the applicable period. The trend is developed from historical FFS data from the three most recent years of complete claims, national trend indices, other expenditure data from Medicaid/Medicare resources, and other States' experience. The resulting trends are applied by category of service. Adjustments are made to include the expected Missouri Home and Community Based Services (HCBS) costs and administrative costs.

Rate Range Methodology

The basis for the capitation rates is the applicable period UPLs. The capitation rates are calculated by applying an upper and lower bound adjustment factor to the UPLs. This adjustment factor is expressed as a percentage and reflects the anticipated PACE savings reduction to the UPL. This guarantees that the State will not pay more than the UPL under PACE as required by regulation.

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PROPRIETARY AND CONFIDENTIAL

May 21, 2004

Ms. Susan Bishop
State of Missouri
Department of Social Services
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102

Subject:
St. Louis Area PACE Upper Payment Limit and Rate Development

Dear Susan:

The State of Missouri (State) engaged Mercer Government Human Services Consulting (Mercer) to review the State's development of the Contract Period 2005 (July 1, 2004 through June 30, 2005) Upper Payment Limits (UPLs) and capitation rate ranges for the St. Louis area PACE program. The State's methodology followed CMS guidelines for UPL and rate development. Historical fee for service (FFS) data from Missouri's nursing home population was used as the basis for the Contract Period 2005 UPLs. Capitation rate ranges were developed by applying a budget factor to the UPL. This letter documents the methodology used by the State to rebase the UPLs for the St. Louis area PACE program, and provides an explanation of the budget factors applied to determine capitation rate ranges.

UPL Methodology

Contract Period 2005 UPL Development

The State followed the methodology required by CMS, using only FFS data to calculate the PACE UPLs. Separate UPLs were developed for individuals dually eligible for Medicare and individuals eligible for Medicaid only. The State used historical FFS data from the three most recent years of complete claims, State Fiscal Years 2000, 2001 and 2002 because the data is believed to be complete, no completion factor adjustments were necessary. Claims were included for eligibles meeting the following criteria:

- Age 55 and older,
- With Medicare (dual eligibles) or without Medicare coverage,

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Supersedes TN No.: 01-10

Approval Date JAN 04 2005
Effective Date 07/01/04

- In a nursing home for more than 32 days, and
- Residing in St. Louis and St. Louis City counties.

The FFS data reflects only State Plan approved services which will be included in the PACE capitation payment. In addition, this data was adjusted to reflect the following:

- Reduction for the State's level of pharmacy rebates,
- Removal of GME from base data,
- Application of any programmatic changes (i.e. – fee schedule and/or benefit changes), and
- Inclusion of patient's liability.

Once these adjustments were applied to the data, each year of data was trended to the base year and combined using credibility blending weights to develop a base fee-for-service equivalent (FFSE). Credibility was applied using a mathematical formula that combined historical periods to smooth outliers and to correct skewed distributions in claims history.

State Fiscal Year	Credibility Weight Applied
2002	70%
2001	20%
2000	10%

The blended FFSE was then trended to the contract period. Trend was applied by category of service. Missouri's historical claims experience, national trend indices, and trend experience for other state's PACE programs were considered in the development of trend. Overall, the annual trend was approximately 3.9% for Medicaid Only and 5.0% for the Dual Eligible population.

Due to a lack of reliable FFS data specific to Missouri for the home and community based population, the base data for UPL development included the nursing home population experience only. Separate adjustments were developed for the Medicaid Only and Dually Eligible groups to account for the differences in utilization of services for the portion of the population receiving services in the home. These adjustments were based on observed experience in other state programs.

Downward adjustments of 1% and 3.5% were applied to the blended FFSE base for the Medicaid only and Dual Eligible PMPMs respectively. The adjustments were developed assuming the PACE UPL represents a FFS population comprised 90% of individuals receiving care in a nursing facility and 10% in a home and community based setting. In addition, Mercer assumed that individuals dually eligible for Medicare receiving care in the home have 65% of the per member costs of individuals receiving care in a nursing facility. For Medicaid only individuals, a 90% relationship of per member costs was assumed. These assumptions were based on data collected from other states' PACE programs.

This base FFSE, representing both the Nursing Home and HCBS populations, was then adjusted to include the State's administrative costs. A 4.25% load was applied to the per member per month to develop the UPLs.

Rate Range Methodology

The basis for the Contract Period 2005 capitation rate ranges is the contract period UPLs. The ranges are calculated by applying an upper bound and lower bound budget percentage factor to the UPLs (Open Cooperative Contracting). This rate adjustment factor is an anticipated managed care savings reduction to the UPL. This guarantees that the State will not pay more than the UPL under this managed care program as required by regulation.

This reduction factor should allow the PACE providers to deliver the contracted services, cover their administrative expenses, and ensure quality care in the appropriate setting. This budget percentage factor accounts for the following differences between the managed care and FFS environments:

- The managed care program goal is to keep nursing home certifiable recipients in the community rather than in an institutionalized setting. Since the UPL reflects the distribution in a FFS environment, which is oriented to institutional care, the rate was adjusted to reflect a greater proportion of members in a community setting under managed care.
- Healthier individuals tend to select a managed care program. For example, PACE programs generally have significantly fewer enrollees that may have traumatic brain injuries or may be ventilator dependent.

The capitation rate ranges (and UPLs) were developed for two separate categories:

- Medicaid Only, and
- Dual Eligibles.

These ranges are fixed and will not change due to a participant's health status. These two rate categories have significant differences in the cost to the State (and the provider) based on coordination with the Medicare program. Due to the small size of the program, experience is not sufficiently credible to develop additional rate categories by age or sex.

Consistent with the CMS guidelines for PACE rate development, the ranges developed are appropriate for individuals without patient liability. For individuals that are responsible for a portion of their own medical costs, the State will adjust the capitation rates downward to remove the costs that should be borne by the individual. The PACE organization will be responsible for collection of this patient liability.

A summary of the Contract Period 2005 Upper Payment Limits and recommended capitation rate ranges has been attached. PACE organizations are advised that contracting at a rate within the recommended ranges may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility of the use of these capitation rate ranges by the PACE organization for any purpose. Mercer recommends that any PACE organization considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these ranges before deciding whether to contract with the State.

Actuarial Certification

The UPLs were calculated consistent with CMS requirements. The UPL calculations are based on claim and enrollment data, which were summarized by the State. Mercer reviewed this data for reasonability and consistency. However, our review of the data did not include an audit. Mercer relied on the data summaries prepared by the State.

Mercer certifies the Contract Period 2005, St. Louis Area PACE UPLs were developed in accordance with generally accepted actuarial practices and principles by actuaries meeting the qualification standards of the American Academy of Actuaries for the populations and services

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covered under the contract with the PACE organization. The UPLs are actuarial projections of future contingent events. Actual results will differ from these projections. Mercer has reviewed these UPLs on behalf of the State to demonstrate compliance with the CMS requirements. Use of the UPLs for any purpose beyond those stated may not be appropriate.

I, the undersigned actuary, am available to answer any questions on this material or to provide explanations or further details as may be appropriate. You may contact me at 612 642 8892.

Sincerely,

Angela L. WasDyke

Angela L. WasDyke, ASA, MAAA

ALW/JS/adl

Copy:
Karin Kreider, Jason Stolte

St. Louis Area PACE Upper Payment Limit and Rate Range Summary

Contract Period 2005 (July 1, 2004 - June 30, 2005)

	Dual Eligibles	Medicaid Only
Upper Payment Limit	$3,303.83	$3,869.60
Upper Bound Budget Percentage	-25.00%	-7.00%
Upper Bound Rate	$2,477.88	$3,598.73
Lower Bound Budget Percentage	-31.00%	-9.00%
Lower Bound Rate	$2,279.65	$3,521.34